STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
45 Fremont Street, 24th Floor
San Francisco, California 94105

INITIAL STATEMENT OF REASONS

INDIVIDUAL DISABILITY POLICY LOSS RATIO REGULATIONS

RH-06092236
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INTRODUCTION

The Insurance Commissioner ("Commissioner") proposes the adoption of amendments to California Code of Regulations ("CCR") Title 10, Chapter 5, Subchapter 2, Article 1.9 ("Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable In Relation to the Premium Charged Pursuant to Subdivision (c) of Section 10293"), sections 2222.10, 2222.11, 2222.12, 2222.13, 2222.14, 2222.15, 2222.16, 2222.17, and 2222.19. The amendments to Article 1.9 would revise existing regulations which implement the portion of Insurance Code section 10293(a) relating to approval of individual policies. These amendments would increase minimum allowable loss ratios so that the policies will provide sufficient economic benefit to policyholders.

The Commissioner proposes the adoption of amendments to these sections pursuant to the authority vested in him by section 10293 of the California Insurance Code. The Commissioner's decision on the proposed amendments will implement, interpret, and make specific the provisions of Insurance Code section 10293.

DESCRIPTION OF THE PUBLIC PROBLEM

1) Purchasers of individual hospital, medical, or surgical policies lack expertise and market power

One of the most significant factors facing purchasers of individual hospital, medical, or surgical insurance is the disparity in expertise and market power between the purchaser and the insurer. While large purchasers of group health insurance have expertise in judging the level of benefit, and market power in negotiating benefits, small groups and individuals lack such expertise and market power. In part as a result of this disparity, the market for individual insurance does not function at full efficiency. This disparity in market knowledge and market power accounts, in part, for the fact that the amount of premium remaining after benefits and expenses is significantly higher for individual hospital, medical, or surgical insurance, as compared to group health insurance.[1]

2) Purchasers of individual hospital, medical, or surgical policies bear an increasing

economic burden

Consumers who purchase individual hospital, medical, or surgical insurance policies face a growing economic burden, as both premium costs and out-of-pocket expenses have significantly increased. This economic burden is consistent with larger trends in health care costs. In the past decades, health care spending in the United States has outpaced the general rate of inflation.[2] Nationally, the amount spent per person on health care increased 74 percent between 1994 and 2004.[3] In addition to the increase in health care costs, the nature of the expenses has changed over the past 20 years, shifting to areas for which the individual hospital, medical, or surgical insurance policyholder often must pay a significant portion of the expense. For example, between 1984 and 2004, the amounts paid for prescription drugs, as a percentage of national health expenditures, increased from 4.9% to 10.0%.[4] From 2001 through 2004, the average annual growth rate in national health care expenditures was 8.4 percent.[5] In the California individual hospital, medical, or surgical insurance market, premiums rose almost 40 percent between 1997 and 2002, in contrast to an approximately 12 percent rise in the prices of other goods and services, as measured by the Consumer Price Index, over the same period.[6]

3) Purchasers of individual hospital, medical, or surgical policies are a vulnerable population

While this environment of rising costs poses challenges for purchasers of individual hospital, medical, or surgical insurance, additional factors make these purchasers particularly vulnerable.[7] First, the individual hospital, medical, or surgical insurance market is the last resort for many; California has a higher rate of persons without insurance and lower rates of employer-sponsored coverage than does the nation as a whole.[8] In addition, the need for individual hospital, medical, or surgical insurance has been increasing due to corporate downsizing.[9] Those who are not fortunate enough to receive insurance through their workplace and are not eligible for public programs must attempt to obtain coverage in the individual market. Once covered by individual insurance, many consumers rely on maintaining that coverage for years. In California, the individual insurance market is an important source of long-term hospital, medical, or surgical insurance coverage for a sizable fraction of those who purchase it.[10]

A second factor that confronts purchasers of individual hospital, medical, or surgical insurance policies is the fact that products in the individual market are difficult to qualify for because they are carefully underwritten to manage risk. A third factor is the rapidly increasing cost of individual insurance. High premiums and the low incomes of many of the potential purchasers of individual insurance makes affordability a particular concern.[11] The increasing expense of individual hospital, medical, or surgical insurance reduces affordability, which in turn reduces availability for consumers who might otherwise be forced to go without vital hospital, medical, or surgical insurance coverage. Also, inadequate benefits in individual insurance coverage can be a major source of underinsurance, which affects 13-20 percent of the privately insured.[12] On average, coverage in the individual hospital, medical, or surgical insurance market is less complete than coverage in the group market.[13] Thus, purchasers of individual hospital, medical, or surgical insurance are faced with rapidly increasing health care costs in general, as well as even more rapidly increasing premiums for individual coverage. Because they have no realistic alternative to individual coverage, such persons are at risk of being priced out of the individual

insurance market, and joining the large number of uninsured Californians.

4) Conclusion

Over forty years ago, the Legislature recognized that the market for individual hospital, medical, or surgical insurance would have to be supported by regulation in order to ensure that policyholders received a reasonable return in benefit for their premium dollar. This regulation increases the efficiency of the market for individual hospital, medical, or surgical insurance. The statutory basis for this regulation, Insurance Code section 10293 (discussed below), provides that approval for a policy may be withdrawn if the benefits provided are unreasonable in relation to the premium charged. Since 1962, the reasonableness of the relationship between benefits provided and premium charged has been a minimum 50 percent loss ratio (calculated by dividing the benefits provided by the amount of premium charged). However, the dramatic transformation of the health care market over the ensuing 44 years has made the 50 percent loss ratio an inadequate standard. Premiums have increased to the point where individual hospital, medical, or surgical insurance has become a heavy economic burden even for those who pass medical underwriting. Increasing out-of-pocket expenses for copays, deductibles, and uncovered care add to this burden. In addition, the purchasers of individual hospital, medical, or surgical policies often have no alternative, and lack expertise and market power. Because of these factors, the legislative mandate of a reasonable relationship between premium charged and benefits received requires that the loss ratio requirement be raised in order to support the individual hospital, medical, or surgical insurance market and ensure that these consumers obtain fair value for their hospital, medical, or surgical insurance dollars.

EXISTING LAW:

Insurance Code section 10293, originally enacted during the 1961 legislative session; requires, among other provisions, that the Insurance Commissioner withdraw approval of individual or mass-marketed policies of disability insurance "if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged."[14] The same Insurance Code section also required that the Insurance Commissioner promulgate "such reasonable rules and regulations…as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy."[15] As a result, on November 30, 1962, the Insurance Commissioner ordered that a new Article 1.9, consisting of sections 2222.10 to 2222.19, be added to the California Administrative Code.[16] This article adopted a "loss ratio" as the means to determine whether the benefits provided by a policy were reasonable in relation to the premium charged. A loss ratio is a measure used by the actuarial profession to evaluate the reasonableness of the benefits provided by a hospital, medical or surgical policy. Here, the "loss ratio" is the ratio of incurred claims to earned premium over the lifetime of a block of insurance business.

As adopted in 1962, section 2222.12, "Standards of Reasonability," provided standards of reasonableness for the ratio of benefits to premium charged in hospital, medical, and surgical policies. These standards were a loss ratio of not less that 50 percent (for policies with annual

premiums in excess of $7.50 per person), and 35 percent (for policies with annual premiums below $7.50 per person). Article 1.9 was subsequently amended in March 1978 to add a minimum loss ratio of 55 percent for Medicare supplement policies.[17] In January 1983, Article 1.9 was further amended to set a revised loss ratio of 60 percent for Medicare supplement policies.[18] However, the loss ratio standard for non-Medicare supplement individual group policies has remained at 50 percent for forty-four years.

SPECIFIC PURPOSE AND REASONABLE NECESSITY FOR REGULATIONS:

The specific purpose of each regulation and the rationale for the Commissioner's determination that each regulation is reasonably necessary to carry out the purpose for which it is proposed is set forth below.

Section 2222.10. Applicability:

Applicability to New Policies

PURPOSE

The amendment to the regulation deletes the 1962 operative date for the regulation, and instead makes the amended regulation applicable to new hospital, medical or surgical policies delivered or issued on or after July 1, 2007. The purpose of the proposed amendment is to set an effective date that ensures that policyholders will obtain the benefits of the increased loss ratio within a reasonable time, while also providing time for insurers to make necessary adjustments to their plans for new products so that the products will comply with the increased lifetime loss ratio established by this amended regulation.

NECESSITY AND RATIONALE

The rationale for the determination by the commissioner that this regulation is reasonably necessary to carry out this purpose is that the designated date provides sufficient time for industry compliance, while addressing the need to promptly ensure that reasonable benefits are provided per premium dollar; a later effective date for the regulation would not serve the purpose of the regulation.

Applicability to Existing Policies

PURPOSE

The proposed amendment to Section 2222.10 also provides that the proposed amendments to Article 1.9 will apply to policies subject to a rate revision effective on or after July 1, 2007. The specific purpose of this amendment is to ensure that consumers who maintain existing policies receive the benefits of the change in the minimum loss ratio at the time of a rate revision.

NECESSITY AND RATIONALE

The commissioner has determined that this amendment is reasonably necessary to carry out this purpose because the same economic forces impinging on future policyholders also affect current policyholders. The rationale for this determination is that many consumers tend to maintain coverage under individual hospital, medical or surgical policies for extended periods of time. Also, other consumers covered by individual hospital, medical or surgical policies may not be able to switch to other policies because changes in their health status render them unable to qualify for a replacement policy due to medical underwriting. These consumers are subject to the same increasing economic burden, and have the same vulnerabilities and lack of expertise and market power, as new purchasers of individual hospital, medical, or surgical policies. However, although they require the benefits of an increased loss ratio, they will not receive these benefits if the proposed regulation applies only to new policies. The proposed amendment, however, only applies to existing policies when a rate revision is filed. The rationale for this is that existing policies (for which no rate revision has been filed) may not be actuarially structured to meet the increased loss ratio requirements, and therefore it would be unduly burdensome to require that they do so. Thus, for existing policies for which no rate revision is sought, the insurer can continue to use the product design and actuarial conclusions previously developed based on the prior regulation.

The proposed amended provisions of Article 1.9 only apply to existing policies after the insurer files a rate revision for the existing policy. However, at the time of a rate revision, the insurer presumably makes adjustments to reflect increases in the costs of medical benefits. As the insurer is making premium adjustments to accommodate increased medical costs, the same adjustments can incorporate changes to bring the product into compliance with the new, increased loss ratio requirement. Because the premium is already being adjusted, making other adjustments to comply with an increased loss ratio requirement at the same time lowers administrative costs (as the insurer is already obtaining and considering premium and cost data for the product in evaluating its rates), and avoids the additional cost to the insurer that would otherwise ensue were the regulation to instead require that all existing policies immediately exhibit the increased loss ratio. Application of this regulation to new and existing policies is reasonably necessary to accomplish the purpose of the regulation, which is to ensure, in an era of rapidly rising medical costs, that reasonable benefits are paid for each premium dollar.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.11. Definitions:

Subdivision (a):

PURPOSE

This definitional subdivision was included as a part of the original regulation when it first became effective in 1962. The purpose of the amendment of this section is to clarify the definition by harmonizing it with subsequent statutory enactments. The amendment incorporates Insurance Code section 106, which was amended in 2001 to provide a definition of "health insurance,' into the definition of a "hospital, medical or surgical policy." Similarly, in 1981 Insurance Code section 10293 was amended to include mass-marketed policies within the category of policies covered by that section. The proposed amendment incorporates the 1981 revision of section 10293 into the definition of "hospital, medical or surgical policy."

NECESSITY AND RATIONALE

The commissioner has determined that these amendments to the regulation are reasonably necessary. The rationale for this determination is that (1) harmonizing the definition with Insurance Code section 106 eliminates potential ambiguities regarding terminology, and (2) explicitly incorporating mass-marketed policies, as provided for in the 1981 amendment to Insurance Code section 10293, ensures that the regulation will achieve the legislative purpose of requiring that mass-marketed policies, as well as individual policies, provide reasonable benefits in relation to the premium charged.

New subdivision (f):

PURPOSE

As noted above regarding the discussion of section 2222.10, the proposed amendment includes a provision that the increased loss ratio requirement will apply to existing policies upon rate revision. Proposed new subdivision (f) provides a definition of "rate revision." The purpose of this amendment, and the rationale for the Commissioner's determination that the amendment is reasonably necessary, is discussed more fully below under the discussion of the proposed amendments to section 2222.12.

NECESSITY AND RATIONALE

Briefly, the definition provides that a "rate revision" occurs when premium rates for existing policies change. The rationale for choosing rate revision as the point at which the loss ratios of existing policies will be reviewed is as follows: Insurance Code section 10290(a) provides that premium rates must be filed with the commissioner. Thus, a change in premium rates provides an appropriate opportunity for the department to determine whether the amount of benefits still bear a reasonable relationship to the premium charged, as the department will already be considering the policy as a result of the filing of the new rate. Similarly, at the time of a rate adjustment, the insurer evaluates the benefits and premiums of the policy, and is already required to provide an analysis of the projected loss ratios for the change in premium. Therefore, insurers already undertake the administrative tasks necessary to ensure compliance with the loss ratio requirements of this article. Consideration of the adequacy of the loss ratio at the time of rate filing thereby achieves administrative efficiency for both the insurer and the State. Use of a change in premium rates as the triggering event is reasonably related to the purpose of the

regulation, as the regulation implements a statute which requires that benefits bear a reasonable relationship to premiums.

New subdivision (g):

PURPOSE

As discussed below regarding the discussion of section 2222.12, the minimum loss ratio standard utilizes a "lifetime anticipated loss ratio," which considers both the actual and anticipated experience, including premium and benefits, over the lifetime of an insurance product. Existing regulation 2222.12 describes the loss ratio calculation as follows: "an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop." This description of the method of "loss ratio" calculation may create the potential for different interpretations, as it is not based on current actuarial terminology. The proposed amendment to the regulation describes the loss ratio calculation as a "lifetime anticipated loss ratio." The purpose of the proposed amendment is to describe the loss ratio calculation using current actuarial terminology in a manner that is specific, clear, and well recognized by the actuarial profession.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that this amendment is reasonably necessary is that the proposed change will describe the calculation method with greater specificity using terms currently accepted by the actuarial profession so that all persons affected by the regulation will clearly understand the method by which the loss ratio is to be calculated.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.12:

PURPOSE

The purpose of the proposed change to this section of the regulation is to ensure that hospital, medical or surgical policies return a reasonable benefit per premium dollar, as required by Insurance Code section 10293.
NECESSITY AND RATIONALE

The Commissioner has determined that the statutory objective of Insurance Code section 10293 is to assure that benefits provided under a policy are reasonable in relation to the premium charged, and that an amended loss ratio standard that reflects current market conditions would reasonably aid the statutory objective. Further, the Commissioner has determined that it is in the interest of insurers to have a market that includes the certainty of an adequate benefit standard

with which all competitors in the market would have to comply. The Commissioner has also determined that a 50 percent loss ratio, developed over 40 years ago in a very different environment of medical cost and insurance coverage, is inadequate to assure sufficient benefits to the consumer without an unacceptable total premium cost. The Commissioner has therefore determined that amending the regulation to require a minimum loss ratio of 70 percent is reasonably necessary to carry out the purpose for which it is proposed.

The rationale for the Commissioner's determination is set forth below:

1) Loss Ratio Regulation: Introduction

In the hospital, medical, or surgical insurance marketplace, large purchasers of group health insurance have expertise in judging the level of benefit. In contrast, small groups and individuals lack such expertise in judging benefits, and also lack market power in negotiating benefits. As a consequence, Insurance Code section 10293(a) recognizes that standards for the reasonableness of benefits are necessary; these standards protect the individual consumer as they purchase this vital coverage in the insurance marketplace.

2) Achieved and designed loss ratios

Data obtained from the insurers with the largest share of the individual hospital, medical, or surgical insurance market in California revealed that, for one insurer, loss ratios for individual major medical policies between 2000 and 2004 ranged from 51 percent to 67 percent, with an average loss ratio of 57.6 percent over 5 years.[19] For another insurer, the loss ratios for individual hospital, medical, or surgical insurance policies ranged from 73 percent to 80 percent, with an average loss ratio of 74 percent; however, this latter insurer includes an "active lives" reserve in its calculations, and so its loss ratio calculations may appear larger than it would otherwise if calculated by the same method as the first insurer.[20]

In testimony at the June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation (file number RH06092236) conducted by the Insurance Commissioner regarding profitability of hospital, medical, or surgical insurance products, representatives of major issuers of California individual hospital, medical, or surgical insurance policies testified that the goal of their respective companies was to design insurance products that generate a loss ratio between 70 and 80 percent.[21] The proposed amended regulation changes the minimum loss ratio level at which the insurance policy will be deemed to be reasonable from 50 percent to 70 percent, thereby supporting the industry at a loss ratio level close to its current product design target level.

3) Costs and Savings in Health Care Market

As discussed extensively above, the health care marketplace has experienced dramatic changes since the existing regulation was enacted, including recent rapid increases in medical inflation. In addition to increases in medical costs, however, other changes in the health care market have resulted in savings. For example, advances in administrative technology over the past 40 years have substantially decreased the cost of data processing and storage, with resulting savings in the

cost of policyholder enrollment and policy maintenance. The efficiencies gained through the use of technology make additional premium dollars available for benefits.

4) Loss Ratio Standards in Other States

In concluding that a 70 percent lifetime loss ratio is reasonably necessary to achieve the statutory purpose, the Commissioner has considered practices in other states. Some states do not regulate loss ratios. Other states have adopted model regulations promulgated by the National Association of Insurance Commissioners (NAIC), in which the minimum loss ratio varies from 50 to 60 percent, based on the level of renewability of the policy. However, even states that have adopted the NAIC approach have modified the required loss ratio; for example, South Dakota requires minimum loss ratios of from 70 to 60 percent, depending on renewability. Other states have loss ratio requirements of 65 percent (West Virginia, Minnesota, Maine, Florida, Colorado). Further, other states have loss ratio requirements in excess of 70 percent. For example, New Jersey has a minimum loss ratio requirement of 75 percent, with an additional requirement of a premium refund if the minimum loss ratio is not achieved in a given calendar year. Also, the state of Washington requires a 74 percent loss ratio, less premium tax, for an effective minimum loss ratio of 72 percent.[22]

5) Conclusion Regarding Loss Ratio Level

In light of the practices of other states, and considering the impact of recent trends in medical cost and premium inflation on purchasers of individual hospital, medical, or surgical insurance policies in California and the stated product design goals of major insurers in the California market, the Commissioner has determined that a lifetime anticipated loss ratio of 70 percent more accurately reflects the current cost of health care and current market conditions. The current 50 percent loss ratio is so far below the market that it is of no utility; it does not provide protection to the benefit levels received by the consumer, nor does it provide a meaningful standard that protects responsible insurers who are providing reasonable benefits to policyholders during a time of rampant medical inflation. The current 50 percent loss ratio would only benefit outliers who design products that undercut the benefits provided by their competitors. The Commissioner has found that the current 50 percent loss ratio does not assure that California consumers will receive reasonable benefits from their insurance premiums. It is therefore reasonably necessary to amend the regulation to provide a loss ratio level that protects both consumers and insurers.

5) Calculation of Loss Ratio

PURPOSE

The proposed amendment to this section also clarifies that the minimum loss ratio of 70 percent is calculated as a “lifetime anticipated” loss ratio. The purpose of this proposed amendment is to clarify the method by which the loss ratio is to be calculated.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that this amendment is reasonably necessary to carry out this purpose is as follows: Existing regulation 2222.12 contains the following language regarding the method where by the loss ratio will be calculated: "an analysis of actual loss experience, giving due consideration to all factors relevant to the determination of how the past loss experience may be used to reasonably indicate the average loss experience which should develop." This description of the method of "loss ratio" calculation does not use current actuarial terminology, and so may create the potential for different interpretations.

The proposed amendment to the regulation describes the method of calculation using current actuarial terminology, a "lifetime anticipated loss ratio." A lifetime anticipated loss ratio considers both the actual and anticipated experience (including incurred claims, changes in reserves, taxes and commission, administrative expenses, and gross margin) over the anticipated lifetime of an insurance product in a way that takes into account random annual fluctuations in earnings and claims, as well as the fact that loss ratios during the early years of a policy are expected to be lower than loss ratios during the policy's later years. Using a lifetime anticipated loss ratio in the calculation of the reasonableness of benefits received incorporates both the historical and anticipated performance of a given policy, and so provides the fairest picture of the design of the insurance policy in terms of how well it will deliver benefits to the consumer. Use of a lifetime anticipated loss ratio therefore benefits insurers, in that it recognizes that loss ratios during the early years of a policy are typically lower, and therefore permits insurers to design their products to take this into account. By comparison, if the loss ratio analysis was based on past experience alone, insurers would be penalized for the low loss ratios experienced in the early years of a policy design. Similarly, consumers benefit from the use of a lifetime anticipated loss ratio, as it assures them that the low loss ratios in a policy's early years will be counterbalanced by benefits received during the later years of a policy. Use of this current actuarial terminology in describing the loss ratio calculation assures that all persons affected by the regulation will clearly understand the method by which the loss ratio is to be calculated.

6) Application to Certain Existing Policies

PURPOSE

The proposed amendment provides that the 70 percent loss ratio requirement applies to new policies delivered or issued on or after July 1, 2007. However, the proposed amendment also makes the 70 percent loss ratio requirement applicable to existing policies at the time a rate revision has been filed. As discussed above regarding the proposed amendment to section 2222.10, the purpose of this amendment is to ensure that consumers who maintain existing policies receive the benefits of the change in the minimum loss ratio at the time of a rate revision.

NECESSITY AND RATIONALE

The commissioner has determined that this amendment is reasonably necessary to carry out this purpose because the same economic forces impinging on future policyholders also affect current

policyholders. The rationale for this determination is that many consumers tend to maintain coverage under individual hospital, medical, or surgical insurance policies for extended periods of time. Also, other consumers covered by individual hospital, medical, or surgical insurance policies may not be able to switch to other policies because changes in their health status render them unable to qualify for a replacement policy due to medical underwriting. These consumers are subject to the same increasing economic burden, and have the same vulnerabilities and lack of expertise and market power as new purchasers of individual hospital, medical, or surgical policies. However, although they require the benefits of an increased loss ratio, they will not receive these benefits if the proposed regulation applies only to new policies.

The proposed amendment, though, only applies to existing policies when a rate revision is filed. The rationale for this is that existing policies (for which no rate revision has been filed) may not be actuarially structured to meet the increased loss ratio requirements, and therefore it would be unduly burdensome to require that they do so. However, at the time of a rate revision, the insurer is presumably making adjustments to reflect increases in the costs of medical benefits. As the insurer is making premium adjustments to accommodate increased medical costs, the same adjustments can incorporate changes to bring the product into compliance with the new, increased loss ratio requirement. Because the premium is already being adjusted, making other adjustments to comply with an increased loss ratio requirement at the same time lowers administrative costs (as the insurer is already obtaining and considering premium and cost data for the product in evaluating its rates), and avoids the additional cost to the insurer that would otherwise ensue were the regulation to instead require that all existing policies immediately exhibit the increased loss ratio. Application of this regulation to new and existing policies is reasonably necessary to ensure, in an era of rapidly rising medical costs, that reasonable benefits are paid for each premium dollar.

The proposed amendment to this section requires that, upon the filing of a rate revision, the policy must demonstrate both a 70 percent lifetime loss ratio for the entire life of the product, as well as a 70 percent loss ratio for the period for which the amended rates are computed. The rationale for this approach is that it encourages insurers to request and implement rate increases in such a way that policyholders are not suddenly confronted with large increases. Also, the proposed amendment prevents companies with existing business who achieved loss ratios in excess of 70 percent due to actual losses prior to the effective date of the proposed regulation from attempting to recoup these losses through a subsequent rate increase that would depress the future anticipated loss ratio below 70 percent. This portion of the proposed regulation is reasonably necessary because large rate increases, or rate revisions that reduce anticipated loss ratios below 70 percent, would impair the ability of consumers to plan for their health costs, and would also result in the consumers sustaining premium costs that do not bear a reasonable relationship to the benefits received.

7) Deleting Obsolete Provision

PURPOSE

The purpose of the proposed amendment to this section is to delete the provision of the 1962 regulation that provided for a 35 percent loss ratio for policies with an annual premium of less

that $7.50 per person. There are no longer policies available at that premium rate, and so this provision is now surplus.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that it is reasonably necessary to delete this provision is that the clarity of the regulation is improved by the removal of obsolete provisions.

8) Harmonizing Medicare Provision with Subsequent Statute

PURPOSE

The purpose of the proposed amendment to this section is to modify the reference to loss ratios for policies designed to supplement Medicare. This provision was added in 1978, and amended in 1983. On both occasions, a specific loss ratio amount was specified. In 2000, Insurance Code section 10192.14 was enacted, specifying a loss ratio amount for policies designed to supplement Medicare. The proposed amendment of this section incorporates Insurance Code section 10192.14(a)(1)(A) by reference, rather than stating a loss ratio amount.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that it is reasonably necessary to amend this provision is that, should Insurance Code section 10192.14 be changed after the regulation is amended, the regulation will automatically incorporate any change in the statutory loss ratio amount without need for further revision. Further, in order to achieve further clarity and specificity, the proposed amendment makes reference to Insurance Code section 10192.4(l), which defines Medicare supplement policies.

9) Title of Section

The proposed amendment changes the title of the section from "Standards of Reasonability" to "Minimum Loss Ratio Standards" in order to achieve improved clarity and specificity.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.13:

PURPOSE

The purpose of the proposed amendment is to remove an obsolete screening procedure from the regulation by deleting the entire section.

NECESSITY AND RATIONALE

Insurance Code section 900 provides that insurers must file an annual statement with the

department. The existing regulation provides for a preliminary screening of policies based on national data obtained from this annual statement (specifically, the accident and health policy experience exhibit of the annual statement blank promulgated by the National Association of Insurance Commissioners ["NAIC"]). However, effective as of 2007 for reports reflecting 2006 data, this NAIC experience exhibit will change from requiring that data be reported based on policy forms to, instead, requiring that data be reported based on type of business. Therefore, the experience exhibit will no longer contain the information needed for the implementation of the existing preliminary screening procedure described by existing section 2222.13. The proposed amended regulation deletes this entire section.

The rationale for the Commissioner's determination that deleting this section is reasonably necessary is that the existing section describes a screening method that can no longer be performed due to changes in the nature of the data available, and is therefore obsolete.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.14: Credibility Factors:

PURPOSE

Credibility factors are an actuarial means of determining whether deviation from a standard may be due to chance variation; for example, an insurance product in which relatively few policies have been sold would ordinarily be expected to show more deviation due to chance variation than would an insurance product with a large number of outstanding policies. The existing credibility factor provision dates back to 1962, and is based solely on outdated premium volume figures. The purpose of the proposed amended provision is to allow the commissioner to consider a broader set of credibility factors, not merely limited to premium volume, in recognizing deviations due to chance variation.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that the amendment is reasonably necessary to carry out this purpose is that it would enable the use of a broader range of credibility factors based on sound actuarial principles. This would enable the commissioner to more completely identify those policies whose deviation below the required standard was due to chance variation. This could avoid the need for further investigation by the department**.** Both the industry and the department would benefit from increased flexibility in making credibility determinations based on sound actuarial principles, rather than being confined to the current outmoded factors provided for in the existing regulation. Needless follow-up investigation and attendant administrative expense could thereby be avoided.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and

reference as is cited in the existing regulation.]

Section 2222.15:

PURPOSE

The purpose of the proposed changes to this section is to make a minor punctuation change that does not alter the substantive meaning of the section. The proposed change is to add a comma after "2222.17" in the introductory clause, as follows: "Prior to taking any action under Section 2222.17, the commissioner will…"

NECESSITY AND RATIONALE

The rationale for the determination that this change is reasonably necessary is that the change conforms the section to commonly accepted standards of punctuation.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.16. Consideration of Relevant Factors:

PURPOSE

The purpose of the proposed changes to this section is to delete the provisions relating to "policies issued on an industrial debit basis." Such policies are no longer issued, rendering these provisions superfluous.

NECESSITY AND RATIONALE

The rationale for the Commissioner's determination that it is reasonably necessary to delete this provision is that the clarity of the regulation is improved by the removal of obsolete provisions.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.17. Notice to Insurer:

The purpose and rationale for the proposed amendments to this section are to enhance readability and clarity, and to substitute gender-neutral terms. The proposed amendments do not represent a substantive change from the existing regulation. In the proposed amendment, the existing text:

> "He shall further advise the insurer that unless within 31 days from the date thereof the insurer has committed itself in writing to the commissioner that it will, within 90 days thereafter, voluntarily either cease further issuance of the policy form or increase benefits under the policy in relation to premiums charged therefor sufficiently that they are reasonable in relation to such premiums, then the commissioner will thereafter, at his discretion, commence proceedings for the withdrawal of authorization of the form after notice and hearing as provided by law. At any time after expiration of said 31 days so specified, and if the insurer has not so committed itself to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings as provided by law for withdrawal of the authorization of the policy form,"

is replaced by

> "The commissioner shall also advise the insurer that the commissioner will, at the commissioner's discretion, commence proceedings for withdrawal of authorization of the form after notice and hearing as provided by law unless, within 31 days from the date of the notification, the insurer commits itself in writing to the commissioner that it will, within 90 days, voluntarily either (1) cease further issuance of the policy form or (2) increase benefits under the policy in relation to the premiums charged in an amount sufficient to bring the policy into compliance with the minimum loss ratio standards provided for in section 2222.12. If the insurer does not commit itself, within 31 days from the date of the notification, to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings at any time as provided by law for withdrawal of the authorization of the policy form."

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

Section 2222.19. Filing Experience Data:

PURPOSE

The proposed changes to this section delete obsolete references to policies with annual premiums of $7.50 or less, and policies issued on the industrial debit basis, as such policies are no longer sold. The subdivisions are also re-numbered to conform to this change. Also, the phrase "pursuant to footnote (5) of the accident and health policy exhibit" is deleted, as the referenced exhibit no longer has a footnote 5.

NECESSITY AND RATIONALE

The purpose and rationale for the Commissioner's determination that it is reasonably necessary

to delete this provision is that the clarity of the regulation is improved by the removal of obsolete provisions.

AUTHORITY AND REFERENCE:
Authority: Insurance Code section 10293. Reference: 10293. [This is the same authority and reference as is cited in the existing regulation.]

SPECIFIC TECHNOLOGIES OR EQUIPMENT

Adoption of these regulations would not mandate the use of specific technologies or equipment.

IDENTIFICATION OF STUDIES

The commissioner considered and relied on the following technical and empirical studies in developing the proposed regulation:

1) "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).
2) Survey of Loss Ratio Requirements in Other States for Individual Health Insurance Policies, July 22, 2006, prepared by Department of Insurance Staff.
3) *Snapshot: Health Care Costs 101, 2006 edition*, California Health Care Foundation, www.chcf.org, pp. 1,4,6,15,14.16.
4) Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, May 2, 2006, www.healthaffairs.org.
5) Buntin, et. al., *Trends and Variability in Individual Insurance Products in California*, Health Affairs,W3-449, Sept. 23, 2003, www.healthaffairs.org

The commissioner also considered and relied upon the following:

6) Transcript of December 1, 2005 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314).
7) Transcript of June 1, 2006 "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).

Copies of these documents are in the rulemaking file.

REASONABLE ALTERNATIVES TO THE REGULATIONS; IMPACT ON SMALL BUSINESS

The Commissioner has identified no reasonable alternatives to the presently proposed regulations, nor have any such alternatives otherwise been identified and brought to the attention of the Department of Insurance, that would be more effective in carrying out the purpose for which the amended regulations are proposed, or which would lessen any impact on small business, than the proposed regulation**.** The direct impact of the proposed regulation is on insurance companies which, pursuant to Government Code section 11342.610(b)(2), are not small businesses. Implementation of an increased loss ratio requirement may, however, benefit small businesses, as the requirement that premiums bear a closer relationship to benefits may result in lower premiums. The Commissioner invites comment regarding the economic impact of the proposed regulation.

Although performance standards were considered as an alternative, they were rejected as ineffective in addressing the problem.

ECONOMIC IMPACT ON BUSINESSES AND THE ABILITY OF CALIFORNIA BUSINESSES TO COMPETE:

The Commissioner has made an initial determination that the proposed regulations may have a significant, statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. The types of businesses that may be affected are insurance companies. This proposed amended regulation continues an existing reporting requirement. The Commissioner has found that it is necessary for the health, safety, or welfare of the people of the state that the regulation apply to businesses.

The Commissioner has not considered other proposed alternatives that would lessen any adverse economic impact on business and invites interested parties to submit proposals. Submissions may include the following considerations:

(i) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to businesses;
(ii) Consolidation or simplification of compliance and reporting requirements for businesses;
(iii) The use of performance standards rather than prescriptive standards;
(iv) Exemption or partial exemption from the regulatory requirements for businesses.

PRENOTICE DISCUSSIONS

The Commissioner conducted a prenotice public discussion of the proposed amendments to the regulations pursuant to Government Code section 11346.45 on June 1, 2006 in Los Angeles, California (Individual Disability Policy Loss Ratio Regulations, file number RH06092236). Written public comments were also received. All comments received by the public comment deadline were considered in formulating the proposed revisions. A transcript of the prenotice public discussion is included in the rulemaking file. Copies of the written comments are also in the rulemaking file.

[1] see, "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236).

[2] As of 2004, the growth rate in national health expenditures was 7.9%, compared with an annual growth rate in the Consumer Price Index of 2.7 percent. Per-capita national health care expenditure in 2004 was 17.6 times the level in 1970, while consumer prices, as measured by the CPI were 4.9 times 1970 levels. *Snapshot: Health Care Costs 101, 2006 edition*,pp.1, 15, 16, California Health Care Foundation, www.chcf.org.

[3] *Snapshot: Health Care Costs 101, 2006 edition*,p.4, California Health Care Foundation, www.chcf.org.

[4] *Snapshot: Health Care Costs 101, 2006 edition*,p.6, California Health Care Foundation, www.chcf.org.

[5] *Snapshot: Health Care Costs 101, 2006 edition*,p.14, California Health Care Foundation, www.chcf.org.

[6] Buntin, *supra* at W3-456.

[7] *Snapshot: Health Care Costs 101, 2006 edition*,p.1, California Health Care Foundation, www.chcf.org.

[8] Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, 227, May 2, 2006, www.healthaffairs.org.

[9] Testimony of Mr. Roupen Berberian, Health Net Life Ins. Co., December 1, 2005 California Department of Insurance Investigatory Heating Regarding Profitability of Health Insurance Companies, (file number IH05049314) RT 64:16-18.

[10] Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, 228, May 2, 2006, www.healthaffairs.org.

[11] Marquis, et al., *Consumer Decision Making in the Individual Health Insurance Market*, Health Affairs, W226, May 2, 2006, www.healthaffairs.org.

[12] Buntin, et. al., *Trends and Variability in Individual Insurance Products in California*, Health Affairs,W3-449, Sept. 23, 2003, www.healthaffairs.org.

[13] Buntin, *supra* at W3-457

[14]Insurance Code section 10293(a)

[15] Insurance Code section 10293(a)

[16] California Department of Insurance Ruling 127, file number RH-89, November 30, 1962, "In the Matter of the Proposed Adoption of Rules and Regulations of the Insurance Commissioner relating to Standards by which the Insurance Commissioner shall withdraw Approval of any Individual Medical, Hospital, or Surgical Policy the Benefits of which are Unreasonable in Relation to the Premium Charge.".

[17] California Department of Insurance Ruling 221, file RH-191, March 21, 1978, "In the Matter of the Proposed Amendments and Additions to the Regulations of the Insurance Commissioner Relating to Individual Disability Policies Designed to Supplement Medicare."

[18] California Department of Insurance Ruling 245, file number RH 218A, January 3, 1983, "In the Matter of Proposed Changes in the Regulations of the Insurance Commissioner Relating to Medicare Supplement Insurance."

[19] "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236), page 7.

[20] "Health Insurance in California: Where Do Your Premium Dollars Go?" PowerPoint presentation by Department of Insurance staff at June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236), page 8.

[21] California Department of Insurance June 1, 2006 Investigatory Hearing Regarding Profitability of Health Insurance Products (file number IH05049314) and Prenotice Public Discussion on Proposed Regulation [Individual Disability Policy Loss Ratio Regulations] (file number RH06092236)., RT 93:8-22, 101:2-105:8.

[22]Survey of Loss Ratio Requirements in Other States for Individual Health Insurance Policies, July 22, 2006, prepared by Department of Insurance Staff.